
THE CONSULTATION RELATIONSHIP—FROM TRANSACTIONAL TO TRANSFORMATIVE: HYPOTHESIZING ABOUT THE NATURE OF CHANGE

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ABSTRACT: Increasing numbers of young children with significant social and emotional difficulties are being identified in childcare settings. Early Childhood Mental Health (ECMH) Consultation has been identified as a promising practice in stemming the tide of this troublesome trajectory. While ECMH Consultation is credited with promoting children's positive development, diminishing difficult behaviors, and reducing expulsion rates, the mechanisms of this transformative process are only beginning to be investigated. Recent research cites the salience of the relationship between a consultant and consultee as the central contributor to positive change in childcare-center climate and child outcomes. This article delineates characteristics of a beneficial consultative relationship and postulates the clinical process by which change in childcare providers' behavior occurs as a result of having experienced such a relationship. Paralleling the traits of contingent caregiving, the consultative stance, a posture of mutuality, reciprocity, and positive regard creates an intersubjective space for reflection, repair, and, when necessary, adaptation. Based on perceptual shifts or expansions, the providers' attitude and approach toward children in their care is amended, in turn promoting positive change in the child and classroom atmosphere.

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Early childhood mental health (ECMH) consultation efforts are growing. The expansion is occurring most extensively in childcare settings. As infants and young children enter childcare in greater numbers and spend longer hours in care outside the home, the effects of group care, especially poor quality care, are more evident (Love et al., 2003; National Institute of Child Health and Human Development, 2000, 2001, 2005). Whether the result of inadequate care or in concert with it, the percentage of children who present concerning emotional and behavioral profiles is escalating (Child and Adolescent Health Measurement Initiative, 2003; Egger et al., 2006; McDonnell & Glod, 2003).

Practitioners and researchers alike have identified ECMH Consultation as a promising practice that lessens children's challenging behaviors and offers concomitant gains in prosocial behavior (Bleecker, Sherwood, & Chan-Sew, 2005; Perry, Allen, Brennan, & Bradley, 2010; Perry, Brennan, Bradley & Allen, 2006; Perry, Dunne, McFadden & Campbell, 2008; Williford & Shelton, 2008). In a national study (Gilliam, 2005) that examined expulsion rates in state-funded prekindergarten programs, children were least likely to be excluded from care when mental health practitioners were predictably present. Conversely, programs with no

access to mental health consultation services had the highest rates of expulsion.

Reduction in expulsions and improvements in child outcomes are likely due to the positive influences of mental health consultation on program practices and caregiver capacity. A corollary set of studies (Alkon, Ramler, & MacLennan, 2003; Brennan, Bradley, Allen, & Perry, 2008; Gilliam & Shahar, 2006; Raver et al., 2008; Virmani & Ontai, 2010) has suggested that mental health consultation enhances classroom quality by improving teacher efficacy, competence, and capacities for reflection and sensitivity.

The pathways of mental health consultation's transformative process are only beginning to be investigated. Recent research has cited the importance of the relationship between a consultant and consultee as the central contributor to positive change in childcare-center climate and child outcomes. Focusing on the characteristics of mental health consultation that correlate with effectiveness, Green, Everheart, Gordon, and Gettman (2006) found that the quality of the mental health consultant-staff relationship was the single most salient predictor of perceived efficacy of consultation services. Increased frequency of the consultant's involvement bolstered the perception of the relationship. Subsequent studies (Duran et al., 2009; Roeser, 2009; Virmani, 2009; Virmani & Ontai, 2010) have confirmed a link between the strength of the consultant-provider relationship and a range of positive program, caregiver, and child outcomes. Although specific mental health consultation approaches that foster beneficial relationships have been described

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(Donahue, Falk, & Provet, 2000; Johnston & Brinamen, 2006), the process by which a positive relationship changes caregivers' behavior has not been fully articulated. In this article, a clinical perspective helps to delineate the characteristics of the consultation relationship that create change. Consultant traits that foster a positive relationship and the transactional process through which change occurs are described.

TRANSACTIONAL PHENOMENON—FROM FORMATIVE TO TRANSFORMATIVE

Relational influences are recognized as the cornerstone of infant mental health. All domains of development are seen to proceed in accord with the quality of the infant's interactions. One's identity—the initial sense of self—derives from the meaning made of messages relayed between the child and his or her primary caregivers in the first days, months, and years of life. For young children, learning—whether about ideas, internal experience, or external realities—cannot be separated from the intersubjective state in which it occurs.

While the early acquisition of knowledge is acknowledged to be relational, explanations for perceptual and/or behavioral change in adults are often devoid of interactional motivations. When others are considered, it is typically as part of an informational exchange. The significance of the relationship, even as a conduit of expanded cognition, is attenuated in theories of change among adults.

The transmission of knowledge is a central contributor to successful ECMH consultation. However, the previously referenced research has suggested that education is not the primary factor in positive change caused by consultation. Even when the content expertise of consultants is sited as salient, the manner in which information is conveyed is significant. Extending this perspective, this article argues that the transformational power of consultation resides in the quality and process of the relationship.

Range of Relational Considerations in Consultation

Describing the mutative components of the consultant–consultee relationship depends on an established understanding and appreciation of the range of relationships considered and encompassed by consultation. Beginning by looking at development from a transactional viewpoint, the provider–child and surrounding adult relationships, both past and present, are discussed.

Development as Transactional

A view of development as an inherently transactional phenomenon has emerged with the recognition of a mutually influencing and co-regulating sphere of interactions between parent and child. Developmental progress is determined by the infant's biological and genetic potentials as they are molded by the quality and nature of the interaction with primary caregivers (Emde & Hewitt, 2001; Stern, 1977, 1985, 1989, 1995; Trevarthen, 1995; Trevarthen & Aitken, 2001).

A young child's primary relationships are potent predictors of emotional development and future relationships. Ready to be confirmed or counteracted, children bring their expectations, attitudes, and feelings about self and others into subsequent relationships. The childcare provider confirms, refutes, or adds to these relationship expectations—a powerful role. The child's course of development and sense of self adapt to the quality of the interaction offered by the substitute caregiver.

As the growth in the number of young children spending significant portions of their lives in childcare accelerates, the relationships offered in these substitute settings are increasingly crucial in determining each child's development trajectory. Consultation efforts are directed at enhancing the central provider–child relationship by attending to it and the surrounding adult relationships, past and present.

Enhancing the Provider–Child Relationship

Understanding the intricacies and complexities of contributors, particularly relational contributors, to the unfolding of development informs or perhaps transforms the intent of ECMH consultation. Viewed through a transactional lens, consultation does not aim to amend a deficiency in a child but rather focuses on the interactions between the child and the adult caregiver, looking to remove impediments when needed, support understanding, and enhance the exchange. Changes in a child's behavior or in the quality of childcare provided all children in a childcare community may be the ultimate goal, but these are secondary to, and an outcome of, incremental adaptations in the adults' interactions with the children. Every child's development depends on and benefits from such shifts.

Adult Relationships Considered

Consultation aims to align providers' ideas about children in their care and appropriate developmental practices with children's developmental capacities and individual needs. In early childhood settings and systems, the provider–child relationship cannot be adequately understood or addressed separately from the many other schemas in which it exists and unfolds (Johnston & Brinamen, 2006).

Dynamics among adults in early childhood settings figure prominently in how children are perceived and treated. The consultant attends to the concentric relational rings surrounding the central provider–child relationship; these usually include numerous adult relationships. Consultation concentrates on exchanges between providers and parents, among program staff, and between consultant and consultee. The tenor of these relationships impacts caregivers' job satisfaction, level of stress, and sense of efficacy; all of which correlate to the quality of care offered to children (Pawl & Johnston, 1991). Consultation targeting adult interactions increases provider's self-efficacy and feelings of competence and

confidence. Specifically, providers who had engaged in consultation for over 1 year reported a greater understanding of and ability to manage challenging child behaviors and a heightened sense of salience in the lives of their child charges (Alkon et al., 2003).

The Consultant–Consultee Relationship as a Clinical Intervention

Inherent in the exchanges between consultant and consultee is the notion that relationships are influenced by past as well as present circumstances. The consultant appreciates the power of and watches for scenarios that suggest transference reactions. Given the inherent intimacy of childcare, enactments are expectable. The residuals of previous relationships can have positive effects, but sometimes cause problematic distortions played out in relationships with children, parents, or consultant. For example, a teacher, whose dependency needs had been largely ignored, adamantly refuses the consultant's offers of assistance only to express resentment that her coworkers get all of the attention. The consultant understands the incongruity of this response as indicative of an intrapsychic conflict.

Advice alone cannot address projections or remedy the effect of emotional constriction on the quality of care. Consultants attend directly to difficulties both intrapsychic and interpersonal by offering information, translating the individuals' meanings and intentions to the other, correcting distortions, and repairing ruptures. Consultants support shifts by using her own relationship with the caregivers—a crucial function of consultation with parallels to psychotherapy as well as to infant mental health. The quality of the consultants' relationship with the caregivers allows room for these sometimes difficult discussions and, perhaps more important, offers therapeutic repair for the caregiver. By creating new relational experiences and subtly challenging relational expectations by their way of being, the consultants hope to create change in the childcare system by offering not just a model for relationship but a relational experience for the adult intended to shift core beliefs and expectations about others. Anchored in an adherence to parallel process, replication in the child–provider relationships is the ultimate goal.

CONSULTANT CHARACTERISTICS THAT CORRELATE WITH CHANGE

That consultees consistently site a positive relationship with the consultant as a primary factor in a consultation's efficacy (Duran et al., 2009; Green et al., 2006; Roeser, 2009; Virmani, 2009; Virmani & Ontai, 2010) lends credence to parallel process as a clinical explanation for change. Particular traits are emerging as emblematic of effective consultation relationships. Organizing these characteristics into categories affords a framework within which to examine and postulate clinical mechanisms of action. The rubrics include *Inquiry Instead of Inquisition*, *Avoid Acting As an Outside Authority*, *Appreciate Subjective Experience*, *Convey Authentic Caring and Genuine Compassion*, and *Shared Vulnerability*.

Inquiry Instead of Inquisition

Beyond building a foundation of trust, the consultants' posture of wondering encourages the provider or parent's participation in the process of discovery (Johnston & Brinamen, 2005, 2006). Conveying genuine interest in the provider's or the parent's experience is sited as essential to establishing confidence in consultants' motives (Duran et al., 2009; Roeser, 2009). Curiosity that exceeds the confines of the consultative concern or question is experienced as caring rather than intrusive when the intention of the inquiry is not deemed presumptive or critical (Roeser, 2009).

Authentic interest summons a space in which collective reflection can occur. The asking rather than offering advice suggests that there is more to be understood about a child or situation than is currently clear to any of the adult participants, including the consultant. This mode of inquiry establishes the consultant as a trusted participant and engenders a culture of curiosity about reasons for behavior, whether that of the children or of the adults.

Successful consultation relies on the consultee's capacity to reflect as well as to generate expanded notions of causality, particularly as they pertain to the possible reasons for a child's behavior. Judgment or accusation, couched as a question, can mobilize the need for self-protection. Defenses cause psychic constriction. Broader understanding is less likely to be entertained, let alone enacted. Therefore, eliciting information already held by the consultee is not only critical to deciphering a child's puzzling developmental profile or uncovering the contributors to an oppressive classroom atmosphere but also to fostering reflection.

When consultees begin to see themselves as the holders of valuable knowledge and thereby as agents of change, they experience positive shifts in self-perception. Gains in caregivers' confidence, efficacy, and competence correlate to constructive changes in childcare quality (Alkon et al., 2003). The core of this reflective practice assumes that "purposeful learning [is derived not from] books or experts, but from our work and our lives" (Amulya, 2004, p. 1).

The reflection proposed in the consultant's inquiry is not always, and especially not initially, seen as helpful. In an atmosphere that demands immediate responses, the slowed pace of pondering challenges and possible contributors that might determine a response seems antithetical. The objection typically takes the form of a demand for decisive action on the part of the consultant. "Just tell me what to do," bemoans the exasperated caregiver of an inconsolable infant. The pull to proffer expert advice is tempting, especially for the inexperienced consultant or one whose orientation is educative rather than dynamically informed (Johnston & Brinamen, 2005, 2006).

One is seeking to instill or expand a consultee's reflective consciousness. Amulya (2004) defined reflection as "an active process of witnessing one's own experience in order to take a closer look at it, sometimes to direct attention to it briefly, but often to explore it in greater depth" (p. 1). Analyzing one's emotional reactions provides insight into the internal landscape of the individual and offers information about the other.

The consultants' request of the provider to consider both their own and another's experience suggests that internal experience exists and can be responded to. Respectful of the consultee's subjective experience, interventions vary in response to the abilities and sensitivities of those involved. The provider who feels ineffective with a distressed infant is encouraged to consider not only his or her own reaction but also the reasons for the child's distress. First empathizing with the consultee, who feels exhausted in the face of perceived rejection, the consultant may wonder what about the child's crying feels like a personal rebuff.

This line of questioning demonstrates awareness at several levels. The tone and content of the consultant's questions convey an appreciation for the consultee's experience. The consultant's inquiry also encourages intersubjective alertness and infers that individuals perceive the world through different prisms of experience. To intervene optimally, providers must recognize that their view is to some degree their own construction. The consultant at once responds to the caregiver's emotions, introduces the idea of internal representations, elicits new ideas about the child, and brings attention to the intersubjective field—key to a transactional view of child, and adult, development.

This examination of the consultee's perceptions and projections as a way of understanding subjective experience hopes to free her from the distortions. Recognizing that an inability to quell this child's distress harkens back to her own experiences, the provider is able to identify connections. Associating alternating expressions of helplessness and rage as similar to affects experienced when unable to please an alcoholic parent, the provider's ambivalence toward this baby becomes more comprehensible. More important, awareness represents a step toward relinquishing the child from the entanglement of the provider's past. Adequately addressing the child's distress is possible only as the transactional entrapment is understood and unwound.

The consultation relationship creates and holds a space for the vulnerability that reflection can engender. By cultivating an environment without appraisal or judgment, consultation affords opportunities for inquiry into one's self and one's practice. Learning through a reflective process facilitated by the consultant is paramount to passing along information and vital to the provider's enhanced ability to be responsive to children.

Recent studies on the effects of ECMH consultation have suggested that a consultative relationship in which reflective capacity is encouraged has a corollary impact on caregiver's insight into and sensitivity toward children's experiences (Virmani, 2009; Virmani & Ontai, 2010). Gains in caregiver's sensitivity in interactions with the children grew as positive perception of the consultative relationship increased (Virmani, 2009). Likely, understanding revealed through conscious reflection and unclouded by subjective interpretations translates into responsive interaction.

Avoid Acting as an Outside Authority

Providers' and parents' perceptions of partnership with the consultant say much about the importance of positioning. Notions of

equity appear especially salient to a consultee's sense of being respected and understood. In studies (Duran et al., 2009; Green et al., 2006) that have identified the consultative relationship as the primary predictor of beneficial outcomes, positive connections were consistently described in egalitarian terms. In the affirmative, being perceived as a partner or team member was an essential quality (Green et al., 2006). Conversely, adopting an elevated or expert position was a derogatory attribute (Duran et al., 2009).

Hierarchy has no place in consultation. Perceptions of power and privilege may be held by or conversely projected upon the consultant. Consultants must maintain an appreciation of the influence of their role while actively asserting equal status with the other participants. As much as not embodying authority, it may be incumbent on consultants to actively refute the consultee's attributions. Alternatively, consultees' may attempt to dislodge the consultant from the position of elevated status, even when that placement is presumed rather than assumed.

The consultant is attentive to actions that belie beliefs about power and authority. Having a broom placed in a consultant's hand during an observation conveys a different meaning than when handed to the consultant after asking if she can be of assistance during a particularly chaotic snack time. The consultant is equally attuned to opportunities to demonstrate parity. Effective partnerships in consultation are predicated on developing mutually held perceptions of equity.

Partnerships in consultation are premised on mutuality, reciprocity, and collaboration. Achieving these essential ingredients demands the consultee's and the family's full inclusion from the inception of the process. The consultant possesses expertise, but how and when it is contributed to the construction of an intervention is jointly decided. Seemingly contrary to the understandable appreciation and wish for mutuality, consultees often adamantly call for advice. Discerning the difference between providers' perceptions of offering guidance and offensively asserting expertise is valuable.

Early in most consultation relationships, providers implore the consultant to direct rather than connect. Frustration with the pace of a collaborative process is common. Confronted with demand and dismay, consultants must avoid the provider's directive and their own desire to give advice that precludes others from offering information. Solutions not developed by all will lack the validity and support necessary for success.

For instance, a director, distraught by the frequent biting of a child, questions the staff's competency. Wishing to be responsive or maybe even convinced that a brilliant and perhaps accurate idea would remedy the problem, the consultant immediately suggests a strategy. Inadvertently aligning with the director's suspicion of the staff's inadequacy, the consultant's advice is seen by the teachers as an indictment of their competence.

Reluctantly, the staff heeds the consultant's recommendation: a teething ring on a string. Most days, the necklace remains buried in the child's cubby, and the biting persists. The well-intentioned and valid offer was doomed to disappoint because the process bypassed the participants on whose success or failure it rested. A

consultant's advice, no matter how ingenious or correct, is useless if it does not consider the consultee's feelings about and understanding of the situation and ultimately the willingness to participate in making change occur (Johnston & Brinamen, 2006).

A spirit of collaboration must be created and supported. The consultant must hold and convey genuine respect for the provider and the parent's perspective. Eliciting consultees' knowledge begins by creating opportunities for sharing it. Sincere solicitation of a consultee's ideas and opinions is an obvious, yet often overlooked, starting point.

When consultation is viewed as a problem-solving endeavor rather than a relational process of reflective facilitation, consultants can be compelled to address a deficiency before fully understanding it. Targeted inquiry assists consultees in identifying the valuable information they possess.

In the course of observing a child whom she has been asked to focus on, a consultant notices that he flits from one area to another, never lighting long enough to engage in an activity. As the child scurries around the room, he appears to make overtures to his peers by brushing against them as he passes. Instead of asking if the observation time was a typical reflection of their experience, the consultant purposefully describes aspects of her observation and then wonders whether the specific behavior is familiar and to what the provider attributes it. Inquiry serves as scaffolding for the consultees to build upon and organize their understanding.

The consultant's respect for the provider's or parent's ideas demonstrates the virtue of mutually constructing hypotheses. The consultant creates and holds a space in which children's behavior can be received as communication. The alchemy of co-creating meaning occurs as understanding is exchanged and synthesized. As ideas derive from collective construction, the parents and providers properly possess an understanding that they helped to develop.

Essential to the implicit as well as explicit experience between consultant and consultee is the sense of creating something together. The partners' intersubjective momentum is in the service of understanding more about the children, and the expansion of the intersubjective field is, in and of itself, crucial. The consultee or parent is more inclined to assert agency when supported by the consultant and free from the constraints of criticism or reprisal. As the direct participants with the child, providers' and parents' sense of efficacy and belief in the co-created intervention is essential.

Appreciate Subjective Experience

As the consultant assists in eliciting the consultee's evolving schema of the child, she listens deeply. A provider or parent's description of a child holds important information about the child. The communication also informs the consultant about the adult's internal experience in relation to the child. By focusing intently on the consultee's attitudes, ideas, intentions, and emotions, the consultant signifies that subjective experience, one's own and that of others, is important.

When witnessing a negative response or attribution toward a child, especially when it is extreme or incongruent, the consultant registers a possible projection. The consultant's interest in the provider's or parent's interpretation is intended to elicit held meaning. Articulating the reasons for one's perceptions necessitates bringing them to conscious awareness.

With the provider's or the parent's permission, the consultant can wonder about the origin of, or contributors to, an attitude, perception, or idea that the adult holds about a child. Seeing a screaming toddler sequestered in the corner of the room, the consultant hears the provider chastising her "greedy grabbing" of a cracker for each hand. The food has been taken, and the child told that she can return to snack only after apologizing to her peers for being "such a little piggy." Conversations with the caregiver reveal the genesis of her intense reaction. Although unconscious until exposed through gentle inquiry, the provider recalls her own early deprivation. Her memories involve being admonished for admiring others' possessions while she watched her younger sister accumulate what seemed an abundance of toys, trinkets, dresses, and dolls. As an adult, she recognizes that the inequity was attributable to her mother's marriage, after the death of her father, to a man for whom her existence represented an intolerable reality. While helpful, the provider's intellectual awareness did not afford inoculation from emotional enactment.

Appreciating the explanation and empathizing with the provider's subjective experience, the consultant does not condone the treatment of the child. Yet, the consultant is sensitive not to recreate the destructive dynamic that perceived criticism could call forth. Shifts in the provider's way of responding occur only as the distortion is identified and the child's behavior is disentangled from the provider's past. Through exploration, the consultant assists in uncovering these connections and freeing the caregiver, and eventually the child, from misperceptions shaped by an adult's subjective interpretation.

Curiosity that leads to an examination of internal experience that can be mutually understood by partners has been coined "reflective dialogue" (Siegel, 2001). The child's capacity to create and communicate a representational self depends on a secure relationship in which interaction is characterized by meaning-making reciprocity (Siegel, 2001). The consultant's relationship to the consultee intentionally mimics this essential attribute of the adult-child relationship. Sensitive recognizing the provider's cues and attributions, the consultant reflects back the meaning of those signals, shifting the provider's representations of self and child. When providers have experienced this reflective dialogue, they are more likely to be able to recreate the experience with children.

Reflecting on an amalgamation of research findings from a range of independent fields, Siegel (2001) stated that "shared subjective experience is one of the most important aspects of human relationships and of psychological development" (p. 90). While this statement and the studies it represents pertained to young children, consultation presumes an adult parallel.

Convey Authentic Caring and Genuine Compassion

Appreciation of another's internal world populated by past and present relational experiences is central to the perception of being known and cared for. Consultees value the consultant's "genuine interest and caring" (Duran et al., 2009)—a way of being that conveys sensitivity, warmth, calm, empathy, and careful listening (Roeser, 2009). While these characteristics are quite broad, they are all affective qualities experienced in relationship.

The need for attuned connection is essential to the developing infant, but it also is important to and characteristic of transformative relationships throughout the life span (Siegel, 2001; Stern, 2004). Adults may no longer regularly depend on others for regulation and a stable sense of self but they continue to reap the benefits of interdependence. In the intimate and emotionally evocative process of caregiving, the adults' regulatory competence is taxed consistently. Interpersonal support assists in maintaining emotional equilibrium and a sense of efficacy.

Although describing a therapeutic rather than a consultative relationship, Stern (2004) proposed that the clinician's exquisitely attuned and resonant responses, often nonverbal, expand the intersubjective arena, thereby allowing participants to tolerate and remain in the immediate moment as past pains are revisited and as greater clarity is achieved. Therapeutic change is attributable to one's way of being with the other. Based on their work with infants and parents, Pawl and St. John (1998) advocated that "How you are is as important as what you do." The power of the consultative relationship also lies in the consultants' way of being. The consultant holds a unique position. Although a member of the childcare community, she or he also is positioned outside the hierarchy and urgency of the setting. The luxury of living outside the system allows the consultant to envision and convey possibilities to which the consultee may be blinded. A regular, consistent presence and relationship to the community's members also allow deep understanding and attunement. Tethered between these positions, the consultant can maintain calm and offer compassion (Johnston & Brinamen, 2006).

Parallel process is intentionally invoked as a mechanism of influence. Most basically, the consultant's careful and empathic attention to the consultee imbues the caregiver-child relationship with similarly essential qualities. Recent studies (Virmani, 2009; Virmani & Ontai, 2010) demonstrated that the caregiver-consultation relationship predicted change in caregiver sensitivity as measured by more positive interaction, less detachment, and less punitiveness.

Shared Vulnerability

Many of the mechanisms of consultation parallel those of psychotherapy—attunement, understanding of subjective experience, attention to the intersubjective space, and affective exploration of past and current experiences. In consultation, the permission for these forays into the unconscious and the past are not implicit, as they are in therapy. Furthermore, consultants do not have the luxury of private, regular, individual meetings. Special

attention must be given to establishing permission for exposing vulnerabilities.

Sometimes, the consultant's interest alone creates the space and safety necessary for personal revelations. A distinction between privacy and confidentiality becomes necessary. When information is shared only with the consultant, she or he agrees not to bring information back to the group without permission. However, given that the task is to hear and represent individual's subjective experience with the ultimate goal of having adults speak directly to one another, the consultant reserves the right to ask questions and make comments informed by individual's experiences. So, a private revelation of fear of conflict due to a caregiver's early experience with a volatile and violent parent is indirectly brought to the group by the consultant's curiosity about how different viewpoints are discussed in the program. The consultant uses knowledge to affect change without revealing the confidential content.

At other times, individuals spontaneously share subjective experiences in the group. Often, these admissions would not have occurred without the query of the consultant. The consultant must prepare the group for this possibility. Group agreements for confidentiality and respect must be made explicit. In addition, the consultant attunes to individual's internal responses to sharing or hearing emotionally charged reflections, fantasies, and histories. Despite the consultant's deep interest in a caregiver's internal experience, he or she occasionally slows down a provider whose emotional dysregulation causes her to reveal more than her sensitivity to vulnerabilities will later tolerate. With parallels to the caregivers' responsibilities in group care, the consultant's attention is both narrow and broad. When one caregiver's disclosure overwhelms another, the consultant might inhibit sharing in the group while inviting individual meetings to protect the group's emotional stability.

Attuned to human motivation and unconscious processes, mental health clinicians acting as consultants may become aware of a caregiver's internal experience, which has neither been shared nor may be immediately evident to the caregiver her- or himself. When caregivers have explicitly offered their experiences, they give implicit consent for acknowledgement and exploration of these processes. Not all groups (or even individuals) are able to initially establish the safety for this type of investigation. The consultant then must help providers envision the possibility of internal representations and their effect on experience. By reflecting on the children's inner world, she already has begun this dialogue, but she needs to also make it salient in the adults' arena. Sometimes, suggesting the possibility is enough. For instance, a light-hearted reminder about a common wish—"I'll never say (or do) that to my children"—is dashed as one replicates that exact parental practice as an adult. Embedded in this reminder are two important tenants of consultation: the idea that unconscious forces propel us toward repetition of past experience despite wishes to the contrary, and the consultant's ability to tolerate and accept these conflicts with compassion.

At consultation's full potential, the consultant and the caregiver share the vulnerability. Much of the time, the consultant's

genuine response to the affective experience of the provider establishes communal exposure and safety. When this is not enough due to an individual's understandable defenses or a lack of shared time and privacy, the consultant must actively create these shared moments. When the consultant is aware of hidden internal forces, she or he might offer personal examples tailored to demonstrating acceptance of the caregiver's struggles. For instance, a consultant observing a program's stringent rule that materials of one play space not be moved into another recognizes that this restriction not only constricts symbolic and creative play but also creates avoidable and regular conflict between the caregivers and children. The rule seems to be rigidly maintained by a single provider's internal call for order. When neither explicit nor implicit permission has been given to the consultant to explore these links, the consultant might offer his or her own anxiety in the face of children mixing vibrant colors of Play-Doh that dissolve into muted browns and the unrealistic wish to remind children to maintain the integrity of each color. This self-disclosure is offered only to create a sense of shared experience and raise connections between internal pressures and the objective world. By highlighting a parallel experience, the consultant hopes to elicit a similar line of dialogue about the classroom environment. Discreetly interjecting personal experience is identified as an essential component of successful consultation relationships (Duran, 2009). Recognizing the parameters and purpose of self-disclosure is incumbent on the consultant.

CONCLUSION

Grounded in the potency of present relationships, ECMH consultation aims to enhance the provider-child interactions. Change in the consultee's attitudes, ideas, expectations, and efficacy occurs interpersonally. More than an exchange of information, the consultant offers an experience—a way of being with another. The transformative power of the consultation relationship makes room for exploration, offers a model for relationships, and can alter consultees' internal experience. Engaged as an egalitarian partner, the consultee is free to investigate conscious and unconscious impediments to understanding children whose optimal development depends on such clarity. The intersubjective space in which exploration occurs also affords moments of genuine attunement. These experiences create new avenues of understanding and shifts in caregiver-child relationships. Positive child outcomes and recently emerging research speak to the efficacy of ECMH consultation that appreciates the transactional nature of development throughout the life span. Further investigation into and articulation of the particular pathways leading to constructive change is needed.

REFERENCES

- Alkon, A., Ramler, M., & MacLennan, K. (2003). Evaluation of mental health consultation in childcare centers. *Early Childhood Education Journal*, 31, 91–99.

- Amulya, J. (2004). *What is reflective practice?* Cambridge, MA: Massachusetts Institute of Technology, Center for Reflective Community Practice.
- Bleecker, T., Sherwood, D., & Chan-Sew, S. (2005). 2003–2004 evaluation report. San Francisco: San Francisco High Quality Child Care Mental Health Consultation Initiative.
- Brennan, E.M., Bradley, J.R., Allen, M.D., & Perry, D.F. (2008). The evidence base for mental health consultation in early childhood settings: Research synthesis addressing staff and program outcomes. *Early Education and Development*, 19(6), 982–1022.
- Child and Adolescent Health Measurement Initiative. (2003). *National Survey of Children's Health*. Portland: Oregon Health & Science University.
- Donahue, P., Falk, B., & Provet, A. (2000). *Mental health consultation in early childhood*. Baltimore: Brookes.
- Duran, F., Hepburn, K., Irvine, M., Kaufmann, R., Anthony, B., Horen, N., & Perry, D. (2009). *What works? A study of effective early childhood mental health consultation programs*. Washington, DC: Georgetown University, Center for Child and Human Development.
- Egger, H.L., Erkanli, A., Keeler, G., Potts, E., Walter, B.K., & Angold, A. (2006). Test-retest reliability of the preschool age psychiatric assessment (PAPA). *Journal of the American Academy of Child and Adolescent Psychiatry*, 45, 538–54.
- Emde, R.N., & Hewitt, K. (Eds.). (2001). *Infancy to early childhood: Genetic and environmental influences on developmental change*. New York: Oxford University Press.
- Gilliam, W.S. (2005). *Prekindergartners left behind: Expulsion rates in state prekindergarten systems*. New Haven, CT: Yale University Child Study Center.
- Gilliam, W.S., & Shahar, G. (2006). Prekindergarten expulsion and suspension: Rates and predictors in one state. *Infants and Young Children*, 19, 228–245.
- Green, B.L., Everheart, M., Gordon, L., & Gettman, M.G. (2006). Characteristics of effective mental health consultation in early childhood settings. *Topics in Early Childhood Special Education*, 26(3), 142–152.
- Johnston, K., & Brinamen, C. (2005). Integrating and adapting infant mental health principles in the training of consultants to childcare. *Journal of Infants and Young Children*, 18(4), 269–281.
- Johnston, K., & Brinamen, C. (2006). *Mental health consultation in childcare: Transforming relationships among directors, staff and families*. Washington, DC: ZERO TO THREE Press.
- Love, J.M., Harrison, L., Sagi-Schwartz, A., van IJzendoorn, M.H., Ross, C.E., & Ungerer, J. (2003). Childcare quality matters: How conclusions may vary with context. *Child Development*, 74, 1021–1033.
- McDonnell, M.A., & Glod, C. (2003). The prevalence of psychopathology in preschool-age children. *Journal of Child and Adolescent Psychiatric Nursing*, 116(4), 141–152.
- National Institute of Child Health and Human Development Early Child Care Research Network. (2000). Characteristic and quality of child care for toddlers and preschoolers. *Applied Development Science*, 4(3), 116–135.

- National Institute for Child Health and Human Development Early Child Care Research Network. (2001). Nonmaternal care and family factors in early development: An overview of the NICHD Study of Early Child Care. *Journal of Applied Development Psychology*, 22, 457–492.
- National Institute for Child Health and Human Development Early Child Care Research Network. (Ed.). (2005). *Childcare and child development*. New York: Guilford Press.
- Pawl, J.H., & Johnston, K. (1991). Daycare consultants final report to the Stuart Foundation: Process evaluation. Unpublished manuscript, University of California, San Francisco.
- Pawl, J.H., & St. John, M. (1998). How you are is as important as what you do . . . in making a positive difference for infants, toddlers and their families. Washington, DC: ZERO TO THREE.
- Perry, D., Brennan, E., Bradley, F., & Allen, M.D. (2006, July). The evidence base on mental health consultation in early childhood settings: Child and family outcomes. Paper presented at Training Institute #21, Implementing Mental Health Consultation: A Promising Practice for Serving Young Children, Orlando, FL.
- Perry, D.F., Allen, M.D., Brennan, E.M., & Bradley, J.R. (2010). The evidence base for mental health consultation in early childhood settings: Research synthesis addressing child behavioral outcomes. *Early Education and Development*, 21, 795–824.
- Perry, D.F., Dunne, M.C., McFadden, L., & Campbell, D. (2008). Reducing the risk for preschool expulsion: Mental health consultation for young children with challenging behaviors. *Journal Child and Family Studies*, 17, 44–54.
- Raver, C.C., Jones, S.M., Li-Grining, C.P., Metzger, M., Champion, K.M., & Sardin, L. (2008). Improving preschool classroom processes: Preliminary findings from a randomized trial implemented in Head Start settings. *Early Childhood Research Quarterly*, 23, 10–26.
- Roeser, A. (2009). Relationship quality in early childhood mental health consultation efforts: A potential mediator for behavior change. Unpublished master's thesis, Johns Hopkins University, Bloomberg School of Public Health, Baltimore.
- Siegel, D.J. (2001). Toward an interpersonal neurobiology of the developing mind: Attachment relationships, “mindsight,” and neural integration. *Infant Mental Health Journal*, 22(1–2), 67–94.
- Stern, D. (1977). *The first relationship: Infant and mother*. Cambridge, MA: Harvard University Press.
- Stern, D. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. New York: Basic Books.
- Stern, D. (1989). The representation of relational patterns: Developmental considerations. In A. Sameroff & R.N. Emde (Eds.), *Relationship disturbances in early childhood: A developmental approach* (pp. 52–69). New York: Basic Books.
- Stern, D. (1995). *The motherhood constellation: A unified view of parent–infant psychotherapy*. New York: Basic Books.
- Stern, D.N. (2004). *The present moment in psychotherapy and everyday life*. New York: Norton.
- Trevarthen, C. (1995). Mother and baby: Seeing artfully eye to eye. In R. Gregory, J. Harris, P. Heard, & D. Rose. (Eds.), *The artful eye* (pp. 157–200). New York: Oxford University Press.
- Trevarthen, C., & Aitken, K.J. (2001). Infant intersubjectivity: Research, theory and clinical applications. *Journal of Child Psychology and Psychiatry and Applied Disciplines*, 42(1), 3–48.
- Virmani, E. (2009). Early childhood mental health consultation: A systematic approach to improving teacher sensitivity through ongoing professional development. Unpublished doctoral dissertation, University of California, Davis.
- Virmani, E., & Ontai, L. (2010). Supervision and training in child care: Does reflective supervision foster caregiver insightfulness? *Infant Mental Health Journal*, 31(1), 16–32.
- Williford, A.P., & Shelton, T.L. (2008). Using mental health consultation to decrease disruptive behaviors in preschoolers: Adapting an empirically supported intervention. *Journal of Child Psychology and Psychiatry*, 49(2), 191–200.